



# CAPM

## Canadian Academy of Psychosomatic Medicine L'Académie Canadienne de Médecine Psychosomatique

141 Laurier Avenue West, Suite 701, Ottawa, Ontario K1P 5J3  
(613) 234-2815 • Fax (613) 234-9857 • E-mail: vanzyll@KGH.KARI.NET

### Application for Membership

**CANDIDATE, PLEASE NOTE:** Your application will not be accepted without the following materials enclosed:

1. Statement describing your current activities in consultation-liaison psychiatry/psychosomatic medicine
2. Statement signed below that you agree to receive an invoice for payment of \$75.00 CAD for (check one)
  - ☐ **FULL MEMBER.** Psychiatrist actively engaged in consultation-liaison psychiatry, medical psychiatry, and / or psychosomatic medicine.
  - ☐ **ASSOCIATE MEMBER.** Individual with advanced degree in a related field and actively engaged in consultation-liaison psychiatry, medical psychiatry, and / or psychosomatic medicine.
  - ☐ **POSTGRADUATE FELLOW / RESIDENT / INTERN / STUDENT (No payment required)**

Please type or print

#### DEMOGRAPHICS

FULL NAME OF CANDIDATE

Graduate degree(s)

First

Middle Initial

Last

Preferred Mailing Address:

Date of Birth

Telephone (Home)

Telephone (Office)

Fax (Office)

E-mail

#### CURRENT PROFESSIONAL POSITIONS

Title	Institution & City	Dates

#### SPECIALTY CERTIFICATION(S)

Royal College of Physicians and Surgeons of Canada in the Specialty of

☐ Psychiatry or

☐ Other (Specify)

**LICENSURE:** Provide jurisdiction and licence number(s)

Have you ever been the subject of disciplinary action by any federal, state, or local professional licensing authority?

☐ Yes (Please submit explanation)

☐ No

**PAST PROFESSIONAL POSITIONS:**

Application for Membership: Canadian Academy of Psychosomatic Medicine

Employment following graduate education, in chronological order. Additional information may be supplied on your curriculum vitae		
Institution and Location	Appointments or Positions	Dates

EDUCATION: Additional information may be supplied on your curriculum vitae			
Institution and Location		Year Graduated	Degree
Medical School			
Internship			
Residency			
Fellowship			
Other Graduate Education			
Postgraduate Education			

**Short Summary of your C/L or Psychosomatic Medicine work experience:**

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**SIGNATURE OF CANDIDATE**

1. I understand that, in order to evaluate my application, the Academy will review my credentials. I agree to cooperate in such review and allow others to provide information regarding my credentials. To the best of my knowledge, all information furnished by me in this proposal is true and complete.
2. I am not including any membership fees with this application, but agree that the Canadian Academy of Psychosomatic Medicine may forward an invoice to me at the contact addresses (mail or e-mail) that I provided above.

\_\_\_\_\_  
Signature of the membership applicant

\_\_\_\_\_  
Date

**Return all requested materials to:**

**Canadian Academy of Psychosomatic Medicine  
141 Laurier Avenue West, Suite 701  
Ottawa, ON K1P 5J3**